

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 1 — 0 1 4

2. STATE:

Arkansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

August 1, 2001

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.179(g)

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 174,020.00

b. FFY 2002 \$ 1,070,883.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Please see attached listing

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Please see attached listing

10. SUBJECT OF AMENDMENT:

To add coverage and reimbursement for Critical Access Hospitals. Attachment 3.1-B, Page 9b
has been included to move personal care from item 23 to item 26 to be consistent with
Attachment 3.1-A.

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Ray Hanley

14. TITLE:

Director, Division of Medical Services

15. DATE SUBMITTED:

May 25, 2001

16. RETURN TO:

Division of Medical Services
P. O. Box 1437
Little Rock, AR 72203-1437

Attention: Binnie Alberius
Slot 1103

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

May 30, 2001

18. DATE APPROVED:

August 3, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

August 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Calvin G. Cline

22. TITLE:

Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

**ATTACHED LISTING FOR
ARKANSAS STATE PLAN
TRANSMITTAL #2001-014**

**8. Number of the Plan
Section or Attachment**

Attachment 3.1-A, Page 9c

Attachment 3.1-B, Page 8c

Attachment 3.1-B, Page 8d

Attachment 3.1-B, Page 9b

Attachment 4.19-B, Page 10

Attachment 4.19-B, Page 10a

**9. Number of the Superseded Plan
Section or Attachment**

Attachment 3.1-A, Page 9c
Approved 08-12-97, TN 97-03✓

Attachment 3.1-B, Page 8c, Items a thru e
Approved 02-25-00, TN 99-30✓

None, New Page✓

Attachment 3.1-B, Page 8c
Item 23.f.

new✓
—NEW PAGE—

Attachment 4.19-B, Page 10
Approved 08-12-97, TN 97-05✓

None, New Page ✓

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-A
Page 9c

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: August 1, 2001

CATEGORICALLY NEEDY

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

d. Nursing facility services for patients under 21 years of age.

A Registered Nurse and a Physician Reviewer assess medical needs and make medical eligibility determinations and patient level of care classifications for applicants referred by a physician for nursing home care.

Nursing facility services include coverage of prescription medications within the State's formulary without limitations.

e. Emergency Hospital Services

Limited to immediate treatment and removal of patient to a qualifying hospital as soon as patient's condition warrants.

f. Critical Access Hospital (CAH)

Services that are furnished by an instate provider that meets the requirements for participation in Medicaid as a CAH and are of a type that would be covered by Medicaid if furnished by a Medicaid enrolled instate hospital to a Medicaid recipient. Services that are not permitted under CAH licensure requirements are not covered by Medicaid.

Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.

CAH services are subject to the same benefit limits as inpatient and outpatient hospital services as described in Attachment 3.1-A, Items 1 and 2a.

SUPERSEDES: TN- AR-97-03

STATE <u>Arkansas</u>	A
DATE REC'D <u>05-30-01</u>	
DATE APPV'D <u>08-03-01</u>	
DATE EFF <u>08-01-01</u>	
HCFA 179 <u>AR-01-14</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 8c

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

Revised: August 1, 2001

MEDICALLY NEEDY

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation (Continued)

(4) Volunteer Transportation

Volunteer carriers are reimbursed for providing transportation to recipients to medical services provided the carriers are registered by the Arkansas Department of Human Services and Medical Services and the medical services are part of the case plan. A General Relief check is issued by local Human Services staff for payment of Medicaid transportation if a licensed carrier is not available.

These services may be billed once per day, per recipient for a maximum of 300 miles per day. The benefit limit does not apply to EPSDT recipients.

(5) Domiciliary Care - The cost of meals, lodging and transportation en route to and from medical care.

b. Services of Christian Science Nurses - Not Provided.

c. Care and services provided in Christian Science sanatoria - Not Provided.

d. Nursing facility services provided for patients under 21 years of age - Not Provided.

e. Emergency Hospital Services

Limited to immediate treatment and removal of patient to a qualifying hospital as soon as patient's condition warrants.

SUPERSEDES: TN- AR-99-30

STATE <u>Arkansas</u>	A
DATE REC'D <u>05-30-01</u>	
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DATE EFF <u>08-01-01</u>	
HCFA 179 <u>AR-01-14</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 8d

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

August 1, 2001

MEDICALLY NEEDY

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

f. **Critical Access Hospital (CAH)**

Services that are furnished by an instate provider that meets the requirements for participation in Medicaid as a CAH and are of a type that would be covered by Medicaid if furnished by a Medicaid enrolled instate hospital to a Medicaid recipient. Services that are not permitted under CAH licensure requirements are not covered by Medicaid.

Inpatient CAH services do not include nursing facility services furnished by a CAH with a swing-bed approval.

CAH services are subject to the same benefit limits as inpatient and outpatient hospital services as described in Attachment 3.1-B, Items 1 and 2a.

SUPERSEDES: NONE - NEW PAGE

STATE <u>Arkansas</u>	A
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
STATE ARKANSAS

ATTACHMENT 3.1-B
Page 9b

AMOUNT, DURATION AND SCOPE OF
SERVICES PROVIDED

August 1, 2001

MEDICALLY NEEDY

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

Not Provided

SUPERSEDES: NONE - NEW PAGE

STATE: <u>Arkansas</u>	AA
DATE RECD: <u>05-30-01</u>	
DATE APVD: <u>08-03-01</u>	
DATE EFF: <u>08-01-01</u>	
HCF# 179: <u>AR-01-14</u>	

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: August 1, 2001

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

f. Critical Access Hospitals (CAH)

Inpatient Reimbursement

Effective for dates of service occurring August 1, 2001 and after, inpatient services that are furnished by CAHs that are enrolled in the Arkansas Medicaid CAH Program will be reimbursed by interim per diem rates with year-end cost settlements. Cost settlements are determined from provider submitted cost reports and are based on 100% of reasonable costs. Reasonable costs is defined as total reimbursable costs under Medicare principles of cost reimbursement for CAHs.

Annual cost reporting requirements are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan. In addition to these requirements, a hospital that converts to a CAH, and whose effective date of Medicaid enrollment as a CAH is a date other than the day following the last day of the facility's established cost reporting period under its enrollment in the Arkansas Medicaid Hospital Program, must submit partial-year cost reports under each program in which it maintained enrollment during the cost reporting period.

Interim per diem rate calculations, access to subcontractor's records provisions, audit function responsibility and the rate appeal procedures are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan.

In addition to the interim per diem rate calculations identified in Attachment 4.19-A, a CAH's initial interim per diem rate will be the most recent interim per diem rate it received under its prior enrollment in the Arkansas Medicaid Hospital Program; or the interim per diem calculated from the most recent full year's cost report it submitted under its prior enrollment in the Arkansas Medicaid Hospital Program. In the event that a hospital enrolled in the Arkansas Medicaid Hospital Program converts to a CAH before it has had an interim per diem rate in effect for a full cost reporting period, the State will set the facility's CAH interim per diem rate at the mathematical mean of established CAHs per diem rates in effect on the date Medicaid establishes as the facility's date of enrollment in the Arkansas Medicaid Critical Access Hospital Program.

COERSEDES: TN- AR-97-05

STATE <u>Arkansas</u>	A
DATE REC'D <u>05-30-01</u>	
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HCFA 179 <u>AR-01-14</u>	

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

August 1, 2001

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary (continued).

f. Critical Access Hospitals (CAH) (continued)

Outpatient Reimbursement

Effective for dates of service occurring August 1, 2001 and after, outpatient services that are furnished by CAHs that are enrolled in the Arkansas Medicaid CAH Program will be reimbursed by minimum interim payment in accordance with the Arkansas Medicaid Program outpatient fee schedule (at the lesser of the billed charge or the fee schedule maximum) with year-end cost settlements. Cost settlements are determined from provider submitted cost reports and are based on 100% of reasonable costs. Reasonable costs is defined as total reimbursable costs under Medicare principles of cost reimbursement for CAHs.

Annual cost reporting requirements are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan. In addition to these requirements, a hospital that converts to a CAH, and whose effective date of Medicaid enrollment as a CAH is a date other than the day following the last day of the facility's established cost reporting period under its enrollment in the Arkansas Medicaid Hospital Program, must submit partial-year cost reports under each program in which it maintained enrollment during the cost reporting period.

Access to subcontractor's records provisions, audit function responsibility and the rate appeal procedures are the same as those for hospitals enrolled in the Arkansas Medicaid Hospital Program as found in Attachment 4.19-A of this Plan.

SUPERSEDES: NONE - NEW PAGE

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